		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046573

Facility Name: Sheldon Health Care Center

Address: 170 West Concord (Number) Sheldon (City) 60966 (Zip Code)

County: Iroquois

Telephone Number: (815) 429-3134 **Fax #** ( )

IDPA ID Number: 743055934006

Date of Initial License for Current Owners: 12/22/03

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,346	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	31	TOTALS	31	11,346	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	9,272	565		9,837	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,272	565		9,837	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.70%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/01/04

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/04 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	85,041	5,817		90,858		90,858	2,711	93,569			1
2	Food Purchase		46,684		46,684		46,684	(184)	46,500			2
3	Housekeeping	74,961	7,684		82,645		82,645	11	82,656			3
4	Laundry	2,998	4,150		7,148		7,148		7,148			4
5	Heat and Other Utilities			32,438	32,438		32,438	(2,998)	29,440			5
6	Maintenance	4,556	17,409	7,326	29,291		29,291	1,694	30,985			6
7	Other (specify):* Mgmt. Co. Benefits							485	485			7
8	**TOTAL General Services**	167,556	81,744	39,764	289,064		289,064	1,719	290,783			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	343,410	9,538	1,942	354,890		354,890	5,957	360,847			10
10a	Therapy							2	2			10a
11	Activities	4,403	1,006	2,305	7,714		7,714	3	7,717			11
12	Social Services	19,172			19,172		19,172		19,172			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt. Co. Benefits							576	576			15
16	**TOTAL Health Care and Programs**	366,985	10,544	4,247	381,776		381,776	6,538	388,314			16
	C. General Administration											
17	Administrative	43,713		26,000	69,713		69,713	7,271	76,984			17
18	Directors Fees											18
19	Professional Services			4,308	4,308		4,308	6,010	10,318			19
20	Dues, Fees, Subscriptions & Promotions			1,313	1,313		1,313	(170)	1,143			20
21	Clerical & General Office Expenses	585	3,666	17,788	22,039		22,039	20,558	42,597			21
22	Employee Benefits & Payroll Taxes			90,605	90,605		90,605		90,605			22
23	Inservice Training & Education			1,495	1,495		1,495	343	1,838			23
24	Travel and Seminar			928	928		928	728	1,656			24
25	Other Admin. Staff Transportation			3,367	3,367		3,367	1,399	4,766			25
26	Insurance-Prop.Liab.Malpractice			19,668	19,668		19,668	489	20,157			26
27	Other (specify):* Mgmt. Co. Benefits							5,644	5,644			27
28	**TOTAL General Administration**	44,298	3,666	165,472	213,436		213,436	42,272	255,708			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	578,839	95,954	209,483	884,276		884,276	50,529	934,805			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sheldon Health Care Center #0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			32,013	32,013		32,013	3,116	35,129			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,140	31,140		31,140	2,770	33,910			32
33	Real Estate Taxes							5,725	5,725			33
34	Rent-Facility & Grounds							1,403	1,403			34
35	Rent-Equipment & Vehicles			456	456		456	49	505			35
36	Other (specify):*											36
37	**TOTAL Ownership**			63,609	63,609		63,609	13,063	76,672			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		368		368		368		368			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			17,019	17,019		17,019		17,019			42
43	Other (specify):* Nonallowable Costs			8,766	8,766		8,766	(8,766)				43
44	**TOTAL Special Cost Centers**		368	25,785	26,153		26,153	(8,766)	17,387			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	578,839	96,322	298,877	974,038		974,038	54,826	1,028,864			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(185)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,993)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,334	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(587)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(25)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,161)	43		28
29	Other-Attach Schedule	(14,779)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (21,396)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	76,222		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 76,222		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 54,826		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sheldon Health Care Center

ID# 0046573

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed Apartment % of Real Estate Taxes	$ (616)	33	1
2	Disallowed Apartment % of Utilities	(3,244)	5	2
3	Allow unposted real estate tax	6,161	33	3
4	Disallow Non-Allowable Dues	(438)	20	4
5	Disallow Non-Allowable Management Fees	(15,000)	17	5
6	Disallow Apartment % of Depreciation	(1,642)	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,779)		49

Sheldon Health Care Center
Provider #: 0046573
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Sheldon Health Care Center # 0046573 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	2,711	0	0	0	0	0	0	0	0	0	2,711	1
2	Food Purchase	(185)	1	0	0	0	0	0	0	0	0	0	(184)	2
3	Housekeeping	0	11	0	0	0	0	0	0	0	0	0	11	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,244)	246	0	0	0	0	0	0	0	0	0	(2,998)	5
6	Maintenance	0	1,694	0	0	0	0	0	0	0	0	0	1,694	6
7	Other (specify):*	0	485	0	0	0	0	0	0	0	0	0	485	7
8	**TOTAL General Services**	(3,429)	5,148	0	0	0	0	0	0	0	0	0	1,719	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,957	0	0	0	0	0	0	0	0	0	5,957	10
10a	Therapy	0	2	0	0	0	0	0	0	0	0	0	2	10a
11	Activities	0	3	0	0	0	0	0	0	0	0	0	3	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	576	0	0	0	0	0	0	0	0	0	576	15
16	**TOTAL Health Care and Programs**	0	6,538	0	0	0	0	0	0	0	0	0	6,538	16
	C. General Administration													
17	Administrative	(15,000)	22,271	0	0	0	0	0	0	0	0	0	7,271	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,010	0	0	0	0	0	0	0	0	0	6,010	19
20	Fees, Subscriptions & Promotions	(438)	268	0	0	0	0	0	0	0	0	0	(170)	20
21	Clerical & General Office Expenses	0	0	20,558	0	0	0	0	0	0	0	0	20,558	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	343	0	0	0	0	0	0	0	0	343	23
24	Travel and Seminar	0	0	728	0	0	0	0	0	0	0	0	728	24
25	Other Admin. Staff Transportation	0	0	1,399	0	0	0	0	0	0	0	0	1,399	25
26	Insurance-Prop.Liab.Malpractice	0	0	489	0	0	0	0	0	0	0	0	489	26
27	Other (specify):*	0	0	5,644	0	0	0	0	0	0	0	0	5,644	27
28	**TOTAL General Administration**	(15,438)	28,549	29,161	0	0	0	0	0	0	0	0	42,272	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,867)	40,235	29,161	0	0	0	0	0	0	0	0	50,529	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheldon Health Care Center # 0046573 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	692	0	2,424	0	0	0	0	0	0	0	0	3,116	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,770	0	0	0	0	0	0	0	0	2,770	32
33	Real Estate Taxes	5,545	0	180	0	0	0	0	0	0	0	0	5,725	33
34	Rent-Facility & Grounds	0	0	1,403	0	0	0	0	0	0	0	0	1,403	34
35	Rent-Equipment & Vehicles	0	0	49	0	0	0	0	0	0	0	0	49	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	6,237	0	6,826	0	0	0	0	0	0	0	0	13,063	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(8,766)	0	0	0	0	0	0	0	0	0	0	(8,766)	43
44	**TOTAL Special Cost Centers**	(8,766)	0	0	0	0	0	0	0	0	0	0	(8,766)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(21,396)	40,235	35,987	0	0	0	0	0	0	0	0	54,826	45

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 2,711	$ 2,711	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	1	1	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	11	11	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	246	246	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,694	1,694	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	485	485	6
7	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,957	5,957	7
8	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	2	2	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	3	3	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	576	576	10
11	V	17	Administrative	11,000	Petersen Health Care, Inc.	100.00%	33,271	22,271	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	6,010	6,010	12
13	V	20	Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	268	268	13
14	Total			$ 11,000			$ 51,235	$ * 40,235	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 20,558	$ 20,558	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	343	343	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	728	728	17
18	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,399	1,399	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	489	489	19
20	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,644	5,644	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,424	2,424	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	2,770	2,770	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	180	180	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	1,403	1,403	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	49	49	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 35,987	$ * 35,987	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Sheldon Health Care Center
provider # 0046573
01/01/04 to 12/31/04

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Casey Health Care Center	Casey, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
El Paso Health Care Center	El Paso, IL
Flora Health Care Center	Flora, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sheldon Health Care Center	Sheldon, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Tuscola Health Care Center	Tuscola, IL
Out-of-State:	
Meadow Lawn Nursing Center	Davenport, IA

Related Assisted Living	
Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL

Other Related Business Entities		
Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100.00	1,059,718	1	2.00	Salary	$ 33,271	L17,C8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,271		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Sheldon Health Care Center
provider # 0046573
01/01/04 to 12/31/04

Schedule 7A

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	$ 89,079	$ 89,071	12,452	$ 2,711	1
2	2	Food	Patient Days	409,056	18	33		12,452	1	2
3	3	Housekeeping	Patient Days	409,056	18	372		12,452	11	3
4	5	Utilities	Patient Days	409,056	18	8,082		12,452	246	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	12,452	1,694	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		12,452	485	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	12,452	5,957	7
8	10A	Therapy	Patient Days	409,056	18	75		12,452	2	8
9	11	Activities	Patient Days	409,056	18	86		12,452	3	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		12,452	576	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	12,452	33,271	11
12	19	Professional Services	Patient Days	409,056	18	197,418		12,452	6,010	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		12,452	268	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	12,452	20,558	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		12,452	343	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		12,452	728	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		12,452	1,399	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		12,452	489	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		12,452	5,644	19
20	30	Depreciation	Patient Days	409,056	18	79,620		12,452	2,424	20
21	32	Interest	Patient Days	409,056	18	90,987		12,452	2,770	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		12,452	180	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		12,452	1,403	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		12,452	49	24
25	TOTALS					$ 2,865,264	$ 1,919,411		$ 87,222	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Sheldon Meadows LLC		X	Mortgage	$5,805.42	01/01/04	$ 500,000	$ 467,280	12/22/14	0.0700	$ 31,140	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$5,805.42		$ 500,000	$ 467,280			$ 31,140	9
	B. Non-Facility Related*											
10												10
11								Allocated from Home Office			2,770	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,770	14
15	TOTALS (line 9+line14)						$ 500,000	$ 467,280			$ 33,910	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 6,161	2
3. Under or (over) accrual (line 2 minus line 1).		$ 6,161	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
	Allocated from Home Office	180	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
	Disallow Apartment Tenants Portion of RE Tax	(616)	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 5,725	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999		8
	2000		9
	2001		10
	2002		11
	2003	6,161	12

Used 100% of 2003 Real Estate Tax.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheldon Health Care Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0046573

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-C-27-02-253-001	LOTS 1 TO 5 BLK 8 VIL OF SHELI	$ 6,160.98	$ 5,544.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 6,160.98	$ 5,544.88

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' X YES NO

NOTE: 10% of the Real Estate taxes relate to apartments on this parcel and have been adjusted out on page 4

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,605 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

10 apartments are maintained on the nursing home grounds.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	Not Available	2004	$ 29,250	1
2					2
3	TOTALS			$ 29,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	31		2004		$ 443,250	$ 16,991	30	$ 14,775	$ (2,216)	$ 14,775	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodeling			7/31/2004	1,175	22	30	16	(6)	16	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 444,425	$ 17,013		$ 14,791	$ (2,222)	$ 14,791	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	183,718	13,113	17,914	4,801	3-10	17,914	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office		2,424	2,424				74
75	TOTALS	$ 183,718	$ 15,537	$ 20,338	$ 4,801		$ 17,914	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 657,393	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,550	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,129	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,579	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 32,705	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments & Land - 2004	$ 52,500	$ 1,642	$ 1,642	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 52,500	$ 1,642	$ 1,642	91

G. Construction-in-Progress

	Description	Cost	
92		$ N/A	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6		Allocated from Home Office			1,403			6
7	TOTAL				$ 1,403 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 505 Description: Oxygen Tanks - $370; Dietary - $72; Equipment - $14; Allocated from Home Office - $49
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Sheldon Health Care Center
Provider #: 0046573
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	227,422	227,422	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,174	7,174	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	26,310	26,310	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 260,906	$ 260,906	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,500	29,250	13
14	Buildings, at Historical Cost	493,675	444,425	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	183,718	183,718	16
17	Accumulated Depreciation (book methods)	(32,014)	(32,705)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Non Care Assets		50,858	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 677,879	$ 675,546	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 938,785	$ 936,452	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 195,707	$ 195,707	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,210	47,210	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	269,569	269,569	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 512,486	$ 512,486	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	467,280	467,280	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 467,280	$ 467,280	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 979,766	$ 979,766	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (40,981)	$ (43,314)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 938,785	$ 936,452	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Sheldon Health Care Center
provider # 0046573
01/01/04 to 12/31/04

Schedule 17A

XV. BALANCE SHEET

C. Current Liabilities **Line 36, Other Current Liabilities (specify):**	Operating	After Consolidation
Assessments	(1)	(1)
Wage Garnishment	(2,401)	(2,401)
Other Withholding	2,470	2,470
Accrued Insurance	19,501	19,501
Interco - Petersen Health Care II	250,000	250,000
	269,569	269,569

SEE ACCOUNTANT'S COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(40,981)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	(40,981)	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	**TOTAL Transfers (sum of lines 18-22)**	$		23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	(40,981)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 932,872	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 932,872	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	185	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 185	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 933,057	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	289,064	31
32	Health Care	381,776	32
33	General Administration	213,436	33
	B. Capital Expense		
34	Ownership	63,609	34
	C. Ancillary Expense		
35	Special Cost Centers	9,134	35
36	Provider Participation Fee	17,019	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 974,038	40
41	**Income before Income Taxes (line 30 minus line 40)****	(40,981)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (40,981)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,324	1,324	$ 33,587	$ 25.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,927	1,945	38,008	19.54	3
4	Licensed Practical Nurses	6,579	6,735	119,309	17.71	4
5	Nurse Aides & Orderlies	14,731	15,381	152,506	9.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	162	162	1,736	10.72	9
10	Activity Assistants	416	430	2,667	6.20	10
11	Social Service Workers	1,475	1,475	19,172	13.00	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,064	25,295	12.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,948	8,105	59,746	7.37	15
16	Dishwashers					16
17	Maintenance Workers	480	480	4,556	9.49	17
18	Housekeepers	10,394	10,394	74,961	7.21	18
19	Laundry	445	475	2,998	6.31	19
20	Administrator	2,033	2,033	43,713	21.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	78	78	585	7.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	50,056	51,081	$ 578,839 *	$ 11.33	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,692	L10, C3	38
39	Pharmacist Consultant	Monthly	250	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 1,942		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Hasbargen	Administrator	0	$ 43,713
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 43,713

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 26,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 26,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LTC Solutions	Computer Services	$ 3,299
ADP	Computer Services	158
CLR Computer Technicians	Computer Services	243
Sheldon Health Care	Computer Services	95
Ginoli & Company	Accounting	53
Bush, Snyder & Assoc.	Legal	460
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,308

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,051
Unemployment Compensation Insurance	6,382
FICA Taxes	39,603
Employee Health Insurance	26,837
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,732
TOTAL (agree to Schedule V, line 22, col.8)	$ 90,605

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	690
Health Care Worker Background Check	
(Indicate # of checks performed 8)	92
License & Permits	45
Dues & Subscriptions	486
Allocated from Home Office	268
Less: Public Relations Expense	(438)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,143

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	633
Seminar Expense	295
Allocated from Home Office	728
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,656

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Sheldon Health Care Center
Provider #: 0046573
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	4,308
Allocated from Management Company - Legal	983
Allocated from Management Company - Other	5,027
Total (agree to Schedule V, line 19, column 8)	10,318

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **789** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **17,019**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **185**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	85,041	5,817	0	90,858	0	90,858	2,711	93,569
2. Food Purchase	0	46,684	0	46,684	0	46,684	-184	46,500
3. Housekeeping	74,961	7,684	0	82,645	0	82,645	11	82,656
4. Laundry	2,998	4,150	0	7,148	0	7,148	0	7,148
5. Heat and Other Utilities	0	0	32,438	32,438	0	32,438	-2,998	29,440
6. Maintenance	4,556	17,409	7,326	29,291	0	29,291	1,694	30,985
7. Other (specify)*	0	0	0	0	0	0	485	485
8. Total General Services	167,556	81,744	39,764	289,064	0	289,064	1,719	290,783
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	343,410	9,538	1,942	354,890	0	354,890	5,957	360,847
10a. Therapy	0	0	0	0	0	0	2	2
11. Activities	4,403	1,006	2,305	7,714	0	7,714	3	7,717
12. Social Services	19,172	0	0	19,172	0	19,172	0	19,172
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	576	576
16. Total Health Care & Programs	366,985	10,544	4,247	381,776	0	381,776	6,538	388,314
17. Administrative	43,713	0	26,000	69,713	0	69,713	7,271	76,984
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	4,308	4,308	0	4,308	6,010	10,318
20. Fees, Subscriptions & Promotion	0	0	1,313	1,313	0	1,313	-170	1,143
21. Clerical & General Office	585	3,666	17,788	22,039	0	22,039	20,558	42,597
22. Employee Benefits & Payroll	0	0	90,605	90,605	0	90,605	0	90,605
23. Inservice Training & Education	0	0	1,495	1,495	0	1,495	343	1,838
24. Travel and Seminar	0	0	928	928	0	928	728	1,656
25. Other Admin. Staff Trans	0	0	3,367	3,367	0	3,367	1,399	4,766
26. Insurance-Prop.Liab.Malpractice	0	0	19,668	19,668	0	19,668	489	20,157
27. Other (specify)*	0	0	0	0	0	0	5,644	5,644
28. Total General Adminis	44,298	3,666	165,472	213,436	0	213,436	42,272	255,708
29. Total General Administrative	578,839	95,954	209,483	884,276	0	884,276	50,529	934,805
30. Depreciation	0	0	32,013	32,013	0	32,013	3,116	35,129
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	31,140	31,140	0	31,140	2,770	33,910
33. Real Estate	0	0	0	0	0	0	5,725	5,725
34. Rent - Facility & Grounds	0	0	0	0	0	0	1,403	1,403
35. Rent - Equipment & Vehicles	0	0	456	456	0	456	49	505
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	63,609	63,609	0	63,609	13,063	76,672
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	368	0	368	0	368	0	368
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	17,019	17,019	0	17,019	0	17,019
43. Other (specify):*	0	0	8,766	8,766	0	8,766	-8,766	0
44. Total Special Cost Ce	0	368	25,785	26,153	0	26,153	-8,766	17,387
45. Grand Total	578,839	96,322	298,877	974,038	0	974,038	54,826	1,028,864

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	227,422	227,422
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	7,174	7,174
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	26,310	26,310
9. Other (specify):	0	0
10. Total current assets	260,906	260,906
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	32,500	29,250
14. Buildings, at Historical Cost	493,675	444,425
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	183,718	183,718
17. Accumulated Depreciation (book methods)	-32,014	-32,705
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	50,858
24. Total Long-Term Assets	677,879	675,546
25. Total Assets	938,785	936,452
CURRENT LIABILITIES		
26. Accounts Payable	195,707	195,707
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	47,210	47,210
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	269,569	269,569
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	512,486	512,486
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	467,280	467,280
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	467,280	467,280
46.Total Liabilities	979,766	979,766
47.Total Equity	-40,981	-43,314
48.Total Liabilities and Equity	938,785	936,452

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	932,872
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	932,872
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	185
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	185
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	933,057
31. General Services	289,064
32. Health Care	381,776
33. General Administration	213,436
34. Ownership	63,609
35. Special Cost Centers	9,134
35. Provider Participation Fee	17,019
37. Other	0
40. Total Expenses	974,038
41. Income Before Income Taxes	-40,981
42. Income Taxes	0
43. Net Income or Loss for the Year	-40,981

Page